An Adaptable and Multi-Faceted Behavior Change Communication/ Information Exchange Communication (BCC/IEC) and Advocacy Strategy: End of Project Report

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Expanding family planning and reproductive health services in Africa

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Expanding Family Planning and Reproductive Health Services in Africa

BEHAVIOR CHANGE COMMUNICATION

END OF PROJECT REPORT

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ACCRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior change communication
CA	Cooperating agency
DRC	Democratic Republic of the Congo
FAWEZI	Forum for African Women Educationalists/Zimbabwe
FP/RH	Family planning/reproductive health
HIV	Human Immunodeficiency Virus
IDP	Internally displaced population
IEC	Information, education, communication
IMC	International Medical Corps
IPC	Interpersonal communication
MCH	Maternal and child health
MOH	Ministry of health
NGO	Non-governmental organization
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
TBA	Traditional birth attendant
TOT	Training of trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United Stated Agency for International Development
ZNFPC	Zimbabwe National Family Planning Council

1.0 INTRODUCTION

In sub-Saharan Africa, poor reproductive health practices can contribute as much or more to maternal and child mortality as does HIV/AIDS. Sadly, unmet need for family planning and reproductive health (FP/RH) services is high. The Advance Africa project (2000-2005) was developed with the mission to reposition family planning, raising awareness among key health and development professionals in Africa about the positive impact FP/RH programs can have on maternal and child health and family wellbeing. Using a holistic approach, Advance Africa's staff and partner organizations focused on enhancing the effectiveness of FP/RH service delivery at the program level. Advance Africa provided technical leadership to improve both clinical and non-clinical services such as addressing the needs of youth, empowering women, involving men in FP/RH decisions, developing private/commercial sector initiatives, and forming links and partnerships between FP/RH and other developmental organizations. The Advance Africa team used strategies to address underserved populations including adolescents, low-parity women, postpartum women, men, and illiterate and impoverished individuals. A key feature of the Advance Africa holistic approach was the Behavior Change Communication (BCC)[1] strategy.

1.1. Advance Africa's Behavior Change Communication; Information, Education, Communication; and Advocacy Approaches

Advance Africa approached Behavior Change Communication (BCC); Information, Education, and Communication (IEC); and advocacy in a broad, multi-faceted strategy. Communication strategies for behavior change and advocacy was implemented through various channels—through interpersonal communication (IPC) between a client and a health provider, through IPC to raise the awareness of decision makers on FP/RH issues, through social mobilization at the community level, through training to improve providers' behaviors and through youth group discussions on reproductive health and life skills. BCC is an exhaustive process that uses several steps to achieve its objectives.

Improving the BCC process took place when Advance Africa started working specifically within countries. Advance Africa responded to local needs of each country by designing multi-faceted and adaptable evidence-based BCC strategies, facilitating and encouraging each country to choose interventions appropriate to its socio-cultural environment and economic situation. Advance Africa provided technical assistance through a wide range of BCC activities including:

- Involving communities and non-health organizations in the promotion of family planning
- Promoting birth spacing as a maternal and child health (MCH) intervention
- Integrating family planning and HIV services
- Repositioning family planning as a priority for family health

The Advance Africa FP/RH BCC strategy focuses on:

- Including an advocacy component to engage decision makers and community leaders

[1] The basis of Behavior Change Communication approach followed by Advance Africa is presented in Annex one of this document.

- Being service-oriented, particularly at locations where health providers are being trained and services are being upgraded
- Including an IPC and counseling component
- Being community-based by encouraging active community participation and/or mobilization
- Including mass media such as rural radio or urban transit advertising to support key messages
- Integrating family planning and HIV/AIDS prevention and de-stigmatization programs
- Involving the private and public sectors in the scaling up process

As Advance Africa initiated work at the country level, it became clear that implementing this holistic communication for behavior change was not realistic and possible given Mission priorities. The following pages present how Advance Africa focused its behavior change communication (BCC) and advocacy efforts in the regions and countries where Advance Africa worked closely with local authorities and communities.

2.0. BCC STRATEGIES

BCC strategies were incorporated into all Advance Africa activities. Each country had specific needs and focus. The following presents Advance Africa's country work from April 2003 to March 2005, responding to the specific needs of changing behaviors for better reproductive health. Countries of focus and specific BCC components included:

- Angola:
  - BCC social mobilization strategy

- Democratic Republic of the Congo (DRC):
  - BCC strategy reinforcing capacity building at ministry of health (MOH) levels
  - BCC strategy strengthening community leaders in FP/RH in internally displaced population (IDP) zones, such as the province of Katanga

- Zimbabwe:
  - HIV/AIDS integration into FP/RH work by providing information and counseling

- Mozambique:
  - BCC social mobilization strategy increasing the mean length of birth intervals among Mozambican women.

2.1. Angola: A BCC Social Mobilization Strategy

2.1.1. Assessment: Specialized attention was given to the BCC strategy while carrying out a Strategic Mapping exercise. The Advance Africa team examined governmental and nongovernmental structures interested in BCC and existing IEC materials related to FP/RH. The team also made sure to involve the director of the Provincial Directorate of Health (Huambo DPS) and the Director of the National Directorate of Health and Reproductive Health Unit (Ministry of Health, Luanda).

The results of the Advance Africa Strategic Mapping showed that the population was not well informed about the benefits of modern contraceptives and that the church had a strong influence on traditional birth spacing. Women in Huambo who were asked to cite reasons for not using contraceptives responded that they did not have contraceptive information (37.1%) or did not know where to go for contraception, while 18.2% said they wanted more children. The majority of the men interviewed believed that birth spacing in two-year intervals was an acceptable practice, but did not know of the health benefits of birth spacing. Men were not opposed to breastfeeding but did not realize how this practice is a family planning method. The young people expressed a need for a place to go for advice on sexual matters. War was sometimes mentioned as a reason for wanting large families even though interviewees recognized economic difficulties as a barrier to having many children.

The team also assessed FP/RH training materials, IEC/counseling support materials, and tools for monitoring family planning services at health centers in the Province of Huambo. The MOH, in

collaboration with Advance Africa, gave an update on tools used to monitor family planning services. The MOH also provided reproductive health training modules developed with UNFPA with technical support and funds. The team observed almost twenty health centers in Huambo, and noted that some of the IEC materials on display were outdated, wordy, and not targeted to specific populations. All off these findings proved that:

1. Health providers needed updated training and IEC support materials
2. The population needed more IEC on family planning
3. Only a few structures were providing these services, meaning that health structures needed support in offering a minimum package of quality FP/RH services

Looking at the demand side of the project, Advance Africa hoped that the project would benefit from existing community-based FP/RH structures, such as previously created community health committees (Reproductive Health Project, International Medical Corps [IMC]). To strengthen the collaboration between nongovernmental organizations, Advance Africa linked its FP/RH work with other NGOs to facilitate the integration of HIV/AIDS and MCH services. For example, in 2003, Population Services International/Angola (PSI/Angola) began a new United Nations Children's Fund (UNICEF)-supported project, which focused on opening a youth information and recreation center in Huambo. The center, named Jango Juvenil, provided youth with educational and recreational activities and reproductive health information and counseling.

Due to the poor economic situation in the area, Advance Africa and its partners (MOH, UNFPA, PSI, IMC, etc.) agreed that the project would provide contraceptives to clients free of charge, according to the current established MOH policy in the area.

2.1.2. Planning: The development of a partnership between Advance Africa and UNFPA/Angola was a major accomplishment that has contributed to the expansion of integrated FP/RH activities in the province. UNFPA/Angola has been active in the health sector and provides needed supplies, equipment, and contraceptives.

New program activities that were planned during CY2004, contributed to the development of integrated post-conflict activities in Huambo. This collaboration was seen as a model for replication in other provinces with support from donor organizations such as USAID.

The BCC strategy was an integral part of a three-pronged approach, with specific tasks assigned to each aspect of the overall reproductive health strategy. They were as follows:

Advance Africa Three-Pronged Approach	**Advance Africa BCC Focus**
System-level capacity strengthening and HIV/AIDS/MCH integration	– Training of health care providers on the benefits of optimal birth spacing, contraceptive methods, and interpersonal communication skills for FP/RH services – Strengthening of supervision skills – Training in the use of birth spacing and family planning

	monitoring tools – Exchange of plans and results of activities with other HIV/AIDS/MCH NGOs
Community organization, education, and social mobilization	– Secondary data analysis and qualitative studies on specific target audiences – Collaboration with existing community structures – Development/adaptation of IEC support materials – Utilization of all kinds of communication to inform, educate, and mobilize the population
Partnership and collaboration with other active organizations in the Huambo area	– Identification of partner organizations – Identification of integration opportunities and interest in birth spacing and family planning – Planning and execution of activities with others

2.1.3. Revision of IEC support materials: The Advance Africa team with the National and Provincial MOH staff looked at the revised FP/RH training manual developed by the MOH and UNFPA for use during training workshops. At the beginning of the project, the team worked on the preparation of content for the training of trainers (TOT) section in FP/RH, interpersonal communication and counselling skills, and supervision skills. Several handouts, worksheets, and tools were adapted, revised, or created. In 2004, the team worked on the preparation and adaptation of all BCC materials to be used in the different training courses (for nurses, health workers, and supervisors). Later, the BCC Unit focused on adapting and developing training content and support materials for village health committee members.

2.1.4. Strengthening Skills: One of the first accomplishments in BCC interventions was to revise the FP/RH modules, for the first FP/RH training of 24 health providers and five supervisors that took place in Huambo in November 2003. Additional training workshops also took place in early 2004, including a logistics information system training (28 participants), a FP/RH training for traditional birth attendants (TBAs) and health workers (160 participants), and a training for 144 health committee members in the integration of FP/RH issues into community-based activities. In March 2004, the team conducted a training course in facility and community-based IEC/BCC activities (focusing on IPC and counseling). Twenty-six nurses and two supervisors took part in the training.

2.1.5. Social Mobilization - Working with specific audiences and/or the community: During the first semester, Advance Africa senior technical staff worked on integrating family planning into Huambo project activities. The topics covered during these interventions included the benefits of family planning for the mother, child, and family as a whole, and activities included:

- Participation in a meeting organized by the Social Sector Support Fund (Fundo de Apoio Social) on the vulnerability of Huambo province.

- Participation in Boy Scout activities in a nearby camp where parents, teachers, and local and religious leaders collaborated to promote the wellbeing of Huambo youth. About 300 people took part in these events discussing such topics as safe sex, child spacing, and HIV/AIDS/STI prevention. Condoms were freely distributed to adolescent and adult participants.
- Presentation of skits on FP/RH aspects during January and February 2004 at a variety of public locations, including:
  - the institute of nursing, three presentations with 360 participants
  - the Protestant Church, one presentation with 400 participants
  - the Catholic Church, one presentation with 80 participants
  - secondary schools, four presentations with 120 students
  - small local market places with an estimated 300 people present
  - Advance Africa project staff with 20 participants
  - the regional prison unit with about 200 participants
  - the Provincial Directorate of Health with 30 participants
  - schools with about 30 participants
- Debates on the benefits of family planning with health workers
- Two soccer games took place—one for men, and one for women

The project worked intensively and creatively with the community to increase its understanding of birth spacing and modern family planning methods, and to establish village health committees to support and promote community-based FP/RH development activities.

In early 2004, the project continued to promote IEC/BCC messages and present skits with the local theater group at health facilities and at the community level in general. Additionally, IEC/BCC information was provided to health workers for the development of IEC/BCC materials that will be used to support and promote FP/RH activities. Partners provided the project with IEC/BCC materials to distribute to health centers in Huambo.

The Advance Africa staff, with various partners, involved teachers and local leaders in promoting family planning services, including the prevention of STIs and HIV/AIDS. Special activities were planned in collaboration with PSI (the lead NGO in HIV/AIDS prevention activities). Advance Africa staff also helped theater groups disseminate family planning information and increase awareness about the dangers of STIs and HIV/AIDS.

In early 2004, health workers (nurses, TBAs, and activistas) were trained in the dissemination of FP/RH information through group counseling and health education sessions at health units and outreach sites. TBAs, activistas, and community leaders were equipped with IEC/BCC materials to support and promote the use of family planning services and the prevention of STI/HIV/AIDS. In addition, five TBAs and five activistas were recruited and trained to assist nurses and village health committees in community-based program activities, using adapted IEC/BCC materials.

2.1.6. Lessons learned:

- Community-based family activities with field-level health workers and village committee members promote ownership and facilitate the adaptability of project strategies into the local environment.

- Project participation in priority health activities facilitates the implementation of essential primary health care (PHC) services and promotes the integration of family planning services into the country's PHC system.

2.1.7. Conclusion: The FP/RH demonstration project in Huambo, which will continue to operate until August 2005, has been a success due to its simultaneous efforts in strengthening the skills of health workers and health facilities, and in its commitment to involving the community.

2.2. Democratic Republic of the Congo (DRC): A BCC Strategy Reinforcing Capacity-Building at the MOH Level

2.2.1 Development of IEC/BCC support material in family planning in the 22 SANRU III health zones: Starting in December 2003, Advance Africa worked closely with the MOH and the SANRU III project to assess available IEC materials in DRC. The team reviewed all existing materials, related to FP/RH, MCH, youth, and HIV/AIDS. Both SANRU and the National Reproductive Health Program implemented the feedback from the assessment into draft materials for a pre-test. With the SANRU III communication team, the MOH developed three leaflets on family planning addressing (a) youth, (b) couples going to health centers, and (c) health providers.

2.2.2. Training in the pre-testing of IEC materials: In April 2004, Advance Africa provided technical assistance for a workshop in the pre-testing of IEC materials. More than twenty experts from the MOH, SANRU, and other USAID cooperating agencies (CAs) revised IEC materials to facilitate the use of FP/RH services. During training, they revised how to pre-test existing support materials using a systematic and evidence-based method. Following the training, several teams pre-tested the materials in the field before production (May 2004).

2.2.3. Co-Training in interpersonal communication and behavior change, primary health care, and contraceptive methods: During 2004, Advance Africa and SANRU III trained a total of 223 providers in the five provinces covered by the project. Training was focused on IPC and behavior change, primary health care, and contraceptive methods. The training of providers was broken down as follows: 35 in Bandundu, 32 in Equateur, 33 in Katanga, 87 in Bas Congo, and 36 in Kasai. SANRU III and Advance Africa split into various co-training teams in order to complete training with all health providers in the 22 health zones.

2.3. A BCC strategy strengthening community leaders in FP/RH in IDP zones, Province of Katanga

In 2004, Advance Africa focused on developing and implementing innovative community-based strategies in the IDP zones of the SANRU III project, Province of Katanga, linking *relais*

communautaires (community health workers), community-based organizations, and healthy facility personnel. The team identified existing community structures while visiting three sites, observing how they were functioning and noting potential collaborators. Advance Africa and SANRU III, along with local physicians (chiefs of the health zones), developed a training curriculum that focused on family planning information and education, social mobilization, and FP/RH community practice, and subsequently trained 90 community leaders in FP/RH.

2.3.1. Curriculum development of a community-based approach and FP/RH integration: The team developed an entire curriculum (seven sessions) for institutional and community leaders and conducted a four-day training. This pre-test of modules allowed for the development of a revised module in family planning collaboration and integration.

2.3.2. Training and information dissemination to community leaders: A total of 90 leaders have been trained and sensitized to FP/RH. They were trained to distribute two forms of contraceptives (pills and condoms), and to refer community members to community health facilities. While visiting and working with IDPs, the team informed more than one hundred community leaders on the benefits of family planning and directed them to places where the community can access family planning services. Focus group discussions and interviews were also conducted among young people and community institutions.

To reinforce health providers' family planning delivery skills with a collaborative community-based approach, updated training in FP/RH for 35 health providers simultaneously occurred with an emphasis on incorporating community leaders from various sectors. The resulting work served as the foundation of a detailed workplan, developed by SANRU and Advance Africa. BCC activities have been successfully implemented since then and incorporated a major recommendation: training in BCC for TBAs in the IDP zones.

2.3.3. Development of a FP/RH community-based strategy:[2] The team developed a FP/RH community-based approach in the three IDP zones using information obtained during field visits. The team closely followed the SANRU community-based approach already in action, with the Community Integrated Management and Childhood Illness program. Furthermore, the proposed strategy closely follows and reinforces different PHC messages developed by the PHC directorate and the MOH. The overall objective of the family planning community-based strategy aims to increase the demand of modern contraceptive methods among the population.

2.3.4. Conclusion: The BCC/IEC interventions demonstrate how Advance Africa's multisectoral efforts to scale up FP/RH interventions by working with existing teams and building capacity with the available human resources are realistic and feasible.

2.4. Zimbabwe: Working Collaboratively to Strengthen the Project—HIV/AIDS Integration into FP/RH Work Through Information and Counseling

To strengthen the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS and FP/RH services in Zimbabwe, Advance Africa collaborated with various groups and institutions

[2] Available in French (separate document): Stratégie a base communautaire en CCC, 2004 (ébauche).

that focused on HIV/AIDS and/or FP/RH. With the Zimbabwe National Family Planning Council (ZNFPC), mission hospitals, the Zimbabwe chapter of the Forum for African Women Educationalists (FAWEZI), and various CAs and NGOs, Advance Africa sought to mitigate the HIV epidemic and strengthen FP/RH services. Advance Africa and ZNFPC have integrated HIV/AIDS prevention into the FP/RH work of community-based distributors and depot holders in 16 districts through information, counseling, and referrals for HIV testing. In addition, Advance Africa launched an integrated family planning and PMTCT initiative in four mission hospitals, working with FAWEZI in life skills education for schools and collaborating with NGOs on reproductive health and life skills for orphans and vulnerable children.

2.4.1. Conclusion: The BCC/IEC work done in Zimbabwe demonstrates the importance of communication and the effectiveness of coordinating differing efforts toward a similar cause between stakeholders and existing community structures, such as hospitals, schools, and orphanages.

2.5. Mozambique: A BCC Strategy to Increase the Mean Length of Birth Intervals among Mozambican Women

2.5.1. Formative Research: The Optimal Birth Spacing (OBS) project was designed and implemented in part to evaluate the feasibility of enacting an intervention based on current knowledge of the community, health providers, families, and specifically women, to promote the benefits of OBS (3-5 years) and the risks of high maternal and child mortality related to short intervals. The results of this intervention can be applied to family planning programs to increase the knowledge about the benefits of OBS.

Between August and September 2004, the team conducted formative research in Gurue District, Zambezia Province; Nacala-Porto District, Nampula Province, and Xai-Xai District, Gaza Province through focus group discussions and interviews. The focus of the research was mainly to find out what women and men with several children, health providers, and midwives knew about child spacing and which social networks were influential in its practice. Findings of this research were used to develop OBS messages and to finding channels for its delivery.

The results from the Gurue District, Zambezia Province were emphasized because operational factors suggested that this site would have the most potential for implementing the follow-up intervention. Overall, the results of the research[3] did not significantly vary between the different audiences. Couples were aware of and seem to able to express some of the benefits of family planning and the majority agreed that birth spacing influenced the health of children. In reality, however, most couples did not space their births with 3-5 year intervals. The question of who or what influenced the fact that the couples did not space 3-5 years thus became a key issue during research. Interviewees often cited that hospitals were the source of their reproductive information and services. It is unclear who or what is directly influencing behaviors, but certainly midwives and traditional nurses are influential. Interviews addressed to authorities, nurses, community

[3] See Optimal Birth Spacing Project in Mozambique, Phase I Summary, March 2005 for more details.

health agents, and traditional midwives confirmed that people were aware of the benefits of OBS but are still hesitant to practice OBS.

2.5.2. Message Development: Based on the main findings of the formative research (phase I), and in preparation for phase II of the project, one message stood out: "To ensure the health of your family, space your children 3-5 years; to know more, visit the hospital or local health center with your spouse."

The research team was able to identify key messages that needed to be pre-tested and adapted to the target audience. They were:

- Learn more about the benefits of OBS
- Visit the local health center to learn more about modern family planning methods and OBS
- Plan your family with your spouse
- Ask for family planning advice
- Use the chosen method properly
- Delay sexual debut—its economic implications and different cultural aspects will require further research to decide how to best approach this topic

2.5.3. Challenges and next steps: It was recognized that even though priority was given to the community, key messages required previous and ongoing efforts, such as (a) helping health providers with support materials for better interaction and transfer of information with their clients, and (b) defining channels of communication—when and how to use IPC (home visits, small group gatherings, face-to-face communication with couples, etc.), traditional communication (i.e. theatre community groups), or mass media, (i.e. rural radio).

At the end of the phase I of the OBS project, the Advance Africa BCC team recommended that to ensure quality of services and increase OBS awareness and use, the project needed to make an ongoing effort to ensure quality of services, meaning that the health providers should:

- be advocates of OBS
- counsel well
- have a positive attitude toward both male and female clients

This can be accomplished with ongoing training and the development of IEC support materials on OBS.

2.5.4. Conclusion: Phase I of the OBS project demonstrates how Advance Africa effectively worked with local teams to develop and implement systematic BCC approaches and methods for target audiences.

3.0. ADVOCACY STRATEGY

3.1. Advocacy's Role in Repositioning Family Planning in Africa

For decades, family planning has been presented as a means to simply control the world's population. The current global situation, particularly that of sub-Saharan Africa, requires a different approach. With the dramatic reduction of the world's population growth rates, due in part to lower fertility and higher mortality caused by HIV/AIDS and other infectious diseases, family planning must be considered a health intervention, not a means of population control. Advance Africa and other family planning groups influence decision makers' understanding of family planning in this capacity and work to reposition family planning in relation to other key public health issues.

The Advance Africa concept of "Repositioning Family Planning" consists of:

- The view that family planning is a critical component of health and development programs
- The effective integration of family planning into other health and non-health activities
- The assurance that all opportunities for addressing men's and women's family planning needs are fully maximized
- Better planning of reproductive health services
- The identification of effective interventions and strategies to improve access to quality family planning services (using promising or best practices)

Advance Africa, in collaboration with numerous agencies (including USAID/Washington, USAID Missions and CAs, donors, health and non-health program managers, and local government), has worked to reposition family planning as a health intervention rather than a population intervention. Today much evidence exists on the benefits of spacing 3-5 years and on unmet need for family planning. The goals of repositioning family planning are to:

- Increase recognition of family planning as a necessary and vital health and development intervention
- Create awareness of the health benefits of family planning and commitment to family planning interventions
- Highlight the specific family planning needs of underserved populations, including youth and people living with HIV/AIDS

Advance Africa advocates for repositioning family planning accomplished through national and regional efforts.

It is worth noting that Advance Africa did not consider advocacy as part of their BCC strategy, but prioritized the development of a specific and unique advocacy strategy as part of the main Advance Africa mandate.[4] The repositioning family planning strategy outlines various components to reposition family planning within the project's scope of work. Technical areas focus on birth spacing, integration of family planning within other health sectors (HIV/AIDS,

[4] See the Repositioning Family Planning Strategy document developed by Advance Africa, 2003

MCH, PHC), and integration of family planning within non-health sectors (education, private sector, environment). This was applied in Zimbabwe (2003), the DRC (2004), USA (2002 and 2004), and Ghana (2005). The following pages summarize the implementation of Advance Africa advocacy strategies.

The two main components of the strategy were:

- National advocacy endeavors to spearhead the Advance Africa strategy
- Co-sponsorship of a regional repositioning family planning conference in Accra, Ghana, in partnership with WHO/AFRO, USAID, POLICY Project, AWARE-RH, UNFPA, IPPF, and the West African Health Organization.

3.2. Presentation of the First Component: The National Advocacy Conferences

3.2.1. Primary Audiences: Target audiences included policy makers, planners from the MOH, community leaders, private sector leaders, program managers, and service providers.

3.2.2. Goal of the conferences: The conferences aimed to introduce the new approach to family planning, the context in which it exists, and how it should be addressed within that context, with an emphasis on the positive impact of OBS. Following the success of various national advocacy conferences, action plans were developed to follow-up repositioning advocacy activities in-country. In DRC, the IEC/BCC unit of the MOH emphasized family planning as a health intervention and highlighted the role of OBS in national health strategies.

- **Preparation work:** Collection of information

Prior to the advocacy conferences, Advance Africa collected information on country-specific demographics, epidemiology, reproductive health services and policies, and contraceptive practices. This review also included questions related to the programmatic aspects of reproductive health interventions (especially regarding family planning, birth spacing, HIV/AIDS, and adolescent reproductive health) in each country, such as policy formulation, strategy development, target groups, results, and major constraints.

In addition, a local person gathered information on local knowledge, attitudes, and practices related to birth spacing among individuals, couples, families, and communities. This information was critical in addressing local programmatic needs based on identified in-country priorities.

- **Products**
  - Report on birth spacing preferences and socio-cultural determining factors
  - Consensus-based recommendations and commitment from participants to support family planning as a priority intervention
  - Action plan outlining family planning as a health intervention on a national scale

- **Outputs**

  - Acceptance of family planning as a health intervention through the incorporation of the family planning action plan in the strategic national health plan, thus creating an enabling environment for family planning activities
  - Increased understanding among key decision makers and other conference participants on the health and non-health benefits of family planning and optimal birth spacing

- **Outcomes**
  - Recommendations and commitments to family planning by participants
  - Strengthened national family planning program planning and implementation
  - Increased financial sustainability of national family planning programs
  - Adapted socio-cultural norms and customs influencing individuals' and families' birth spacing practices

3.2.3. Secondary Audiences—The media: In order to increase awareness and involve communities in their public health, Advance Africa recognized the important role of the media. Journalists have access to a range of media outlets, including newspapers, television, and radio. Many journalists focus on the ravaging effects of HIV/AIDS and neglect FP/RH, including its impact on HIV/AIDS infection and services. Therefore, it was imperative that Advance Africa worked with journalists to expand their training in reproductive health reporting.

Journalists were exposed to reproductive health issues in the field and invited to national advocacy conferences where they were exposed to reproductive health policy and programmatic issues. This sequence of events led to:

- Journalists' enhanced understanding and capacity to report on critical issues and educate the public
- Reproductive health training being brought to a practical level in the field by interviewing providers and clients who were able to see firsthand how issues affect them on a daily basis
- Journalists receiving further information at the conference on local policies and issues specific to their country at the macro level
- The opportunity for journalists to observe and interview the country's policy makers and stakeholders at the programmatic level
- The collection of information on theory, policy, programs, and on-the-ground realities for writing feature articles and informing radio and television shows
- Journalists' networking with reproductive health policy makers, program managers, and service providers for future reporting
- The overall training of writers on the ground both for raising public awareness and for contracting writing assignments

3.3. Presentation of the second component: Co-sponsorship of a four-day regional conference on repositioning family planning in Accra, Ghana with WHO/AFRO and WAHO

3.3.1. Process: This activity was part of the Advance Africa's mandate, Repositioning Family Planning: An Advance Africa Global Strategy (January 2004). Its goal was to address the declining international focus on family planning and its impact on health and development. It was geared toward reviving the interest of donors and governments in the domain and increasing unmet need for family planning. The agenda focused on providing a forum for key stakeholders in West Africa to repositioning family planning as a means of combating unmet need. The conference's main objectives were to:

- Provide comprehensive data on the expressed need for family planning in West Africa
- Identify key factors underlying the gap between expressed need for family planning and the use of family planning
- Discuss the health and development consequences of this gap
- Explore solutions for addressing the gap
- Demonstrate how advocacy can be used to implement solutions
- Develop strategies for participants to undertake after the conference to advance repositioning family planning efforts in their respective countries

Conference participants mainly consisted of multi-sectoral country teams and their partners. Participating country teams were from Benin, Burkina Faso, Chad, Cote d'Ivoire, Ghana, Guinea, Guinea-Bissau, Madagascar, Mali, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, and Togo. The conference registered about 255 delegates from thirteen West African countries as well as two countries outside of West Africa. The conference was broken down into plenary and breakout group thematic sessions, as well as country team exercises. This allowed participants to be actively involved in the evolution of the conference. At the end of the conference each country developed and presented a follow-up plan for their respective countries.

3.3.2. Conclusion: Participants recognized the conference as an opportunity to share experiences and lessons learned to help find realistic and sustainable solutions, based on each country's reality and needs. Advocacy for the review of a final draft on FP/RH policy and advocacy addressed to religious and traditional leaders were a common priority for many of the countries.

Annex 1: BASIS OF BEHAVIOR CHANGE COMMUNICATION APPROACH FOLLOWED BY ADVANCE AFRICA

Role of Behavior Change Communication (BCC)

Evidence has shown that BCC strategies are critical in improving health outcomes in FP/RH, HIV/AIDS prevention, and stigma reduction. More than simply raising awareness, BCC focuses on actually moving the target audience and important intermediary audiences (primary and secondary audiences) to take action. Such strategies encompass a variety of approaches including interpersonal communication, community/social mobilization, and advocacy.

Key Components of Behavior Change Communication (BCC)

Behavior change communication is distinctive in its name—*behavior change*. While providing information can be an important step in achieving behavior change, because people are unable change that they are unaware of, information itself is not enough. BCC therefore must start at the end result—the behavior to be changed—and works backwards to develop strategies and messages based on a deeper understanding of the audience

Generally, BCC encompasses strategies such as:

- **Direct interpersonal communication:** health provider training, interpersonal communication and counseling for clients, health facility activities, and mass media campaigns
- **Social mobilization:** developing community networks; working with community leaders, religious leaders/organizations, and women's groups; workplace activities
- **Advocacy:** conducting workshops and presentations with stakeholders, religious and political leaders/policymakers, opinion leaders, and national and regional health program managers

Key Aspects of Behavior Change Communication

This section highlights the key aspects of BCC that are important to note as BCC initiatives are being implemented.

Why do people change their behavior? Theories to Guide You

Why do people change their behavior? Why would a woman use contraceptives to allow three years between her first and second pregnancies? The answers are obviously complex, and there are a small set of theories and models that BCC managers use to structure their programs. The main behavior change theories are: the Health Belief Model, Theory of Reasoned Action, Social Cognitive Learning Theory, and Stages of Change (or the Transtheoretical) Model. A BCC program manager identifies a theory or model that provides a logical framework and applies it to his or her research and strategies. Many resources on these BCC can be found online (i.e. http://www.jhuccp.org/, http://www.comminit.com/, and many more).

Segment and Know your Target Audience

A successful BCC program will not try to reach all people simultaneously and use the same messages/activities. Those that make this attempt usually fail miserably. However, by identifying more specific demographics, BCC managers can use audience research to better understand the audience and learn what will motivate them to adopt a specific behavior. There are several ways to accomplish this, some more systematic than others. Two common approaches are:

Conducting a "doer vs. non-doer" analysis approach
One useful way to analyze behavior change is by comparing those people who practice a behavior (the "doers") with those people who do not (the "non-doers"). Looking at doers and non-doers of a certain behavior can unearth important differences in attitude or perception, which ia key to promoting the behavior. Everything flows from this knowledge of the audience—BCC strategies, creative messages and materials, and other activities. This helps avoid inefficient efforts in program activities that do not move the audience to action, or more the program forward. By observing the differences between the two groups, people can identify factors that favor the adoption of a specific behavior. The box below gives an example of a doer-non-doer analysis for condom use.

Doers vs. non-doers

When the men in the focus groud discussions (FGD) were asked if they used condoms, the majority of them had a disapproving look on their faces. They did not feel that HIV was a problem in their village. They felt uncomfortable discussing condom use with their wives. Most of these men had not gone to secondary school.One man, however, said that he now uses condoms each time and had talked about it with his wife. He had a brother who died of AIDS, and felt at risk himself. This man was unusual because he had gone to secondary school.

Doers (using condoms)	Non-doers (not using condoms)
•Feels vulnerable to getting HIV •Is comfortable talking with wife about sexual issues •More likely to have gone to secondary school	•Does not believe HIV is a problem in this community •Does not discuss sexual issues with wives •Has not gone to secondary school

Review the behavior change(s) that is/are the subject of your project. For each desired behavior change, compare the doers with the non-doers.

- How are they different?
- What does this tell you about the behavior?
- What does this tell you about opportunities for fostering behavior change?

Positive Deviance (PD) (AED, The Change Project)

The other asset-based approach is the positive deviance (PD) approach. The PD approach studies individuals, families, and communities who already practice a desired health behavior (positive deviants). It observes what positive deviants are doing and how they overcome the same constraints confronted by others. The results of such an inquiry can help design more effective behavioral change activities. PDs are often used as a formative research tool to help understand a particular problem.

There are several steps involved in the process:

- Defining the community
- Determining PDs in the community
- Discovering what they are doing differently
- Designing intervention(s) based on the findings
- Disseminating findings and intervention approaches

Why do people take or not take action?

Looking at Determinants of Behavior

When interpreting people's behaviors and thinking about how it might be possible to change these behaviors, it is important to distinguish between what participants *believe* vs. what they actually *do*. People often behave in a way that is inconsistent with their beliefs.

Desired vs. Actual Behaviors

A female FGD participant believes that she should use a contraceptive method to space her children and have a better health. She does not take any contraceptive method however because her husband does not believe in family planning. Therefore, "taking a contraceptive method" is her desired behavior, but "not taking any" is her actual behavior.

Identify the determinants of behavior change

Another step is to look for factors that "determine" whether or not a specific target audience adopts and maintains a behavior. There are both external and internal "determinants" that can influence behavior:

- ***External determinants of behavior changes*** are forces outside of a person that influence their behavior. They include:

  - **Culture:** Lifestyles, values, and practices within a community
    Example: Men have more decision-making power than women in relationships.
  - **Access to services:** The existence of services and products and their availability to an audience
    Example: The lack of family planning services at health centers
  - **Actual consequences**: What happens as a result of adopting a specific behavior
    Example: When a woman suggests to her husband that she wants to use a contraceptive method, her partner will feel she is cheating him and will tell her to leave the house

- **Skills:** The set of abilities necessary to perform a particular behavior.
  Example: The ability to negotiate family planning contraceptive use
- **Policy**: Laws and regulations that affect behaviors and access to products and services.
  Example: A country that does not promote more than a few family planning methods.

- ***Internal determinants of behavior change*** are the forces inside a person. They include:
  - **Self-efficacy:** An individual's belief that he/she can do something for him/herself
    Example: A woman's belief that she can use a condom correctly.
  - **Perceived social norms:** A person's perception of how society views a particular behavior
    Example: The perception that a "good girl" does not use modern contraceptive methods
  - **Perceived consequences:** What a person thinks will happen, either positive or negative, as a result of performing a behavior
    Example: A woman thinks that if her friends know that she is taking a modern contraceptive method, it is because she is having various sexual partners.
  - **Knowledge:** The information that a person has about a particular reproductive health issue
    Example: Young people's knowledge of the benefits of modern contraceptive methods
  - **Attitudes**: What an individual thinks or feels about a reproductive issue
    Example: How a young person feels about friends of theirs who are infected with HIV
  - **Perceived risk:** A person's perception of how vulnerable they are to a specific action
    Example: The degree to which a young person feels at risk of becoming pregnant after a casual sexual relation
  - **Intentions**: What an individual plans to do in the future
    Example: A woman with four children intends to follow family planning by taking a modern contraceptive method.

BCC Interventions

When initiating a BCC intervention, it takes time due to various obstacles such as little sociopolitical support or if it is not endorsed by national policy. It is recommended therefore that when starting a program, project implementers seek for the best methods with a high level of success, looking for positive determinants that will facilitate the intervention.

Once the situation becomes clear after conducting a situational assessment, the behaviors that should change become more apparent. It is then time to think about the content of the messages and to define target audiences. This will also help decide the best communication channels to use, which determines the format of the messages. For example, written messages on a poster have a different format than messages on a pamphlet, or oral messages for the radio. There is variation within these formats too, as in the length of a message developed for a radio spot versus longer messages for a radio story type of program. Finally, it is important is to use different channels repeating the same message, so that people will be reassured of the message.